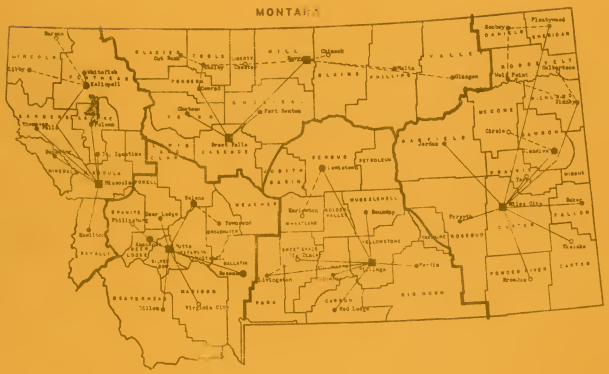
MONTANA
STATE PLAN
for
HOSPITAL CONSTRUCTION



HOSPITAL SURVEY & CONSTRUCTION DIVISION
STATE BOARD OF HEALTH
B. K. Kilbourne, M.D., Executive Officer
Helena, Montana

E R R A T A

Under "MEMBERS OF STATE BOARD OF HEALTH", the residence of Mr. R. J. Losleben is Malta rather than Havre as shown.

Page 6 The third paragraph under "III. THE ALLOCATION OF HOSPITAL BEDS TO EACH AREA" is changed to read:

"Montana has at present 63 general hospitals with a total of 2,893 beds, or 6.1 beds per thousand population, somewhat higher than the overall requirements. However, 577 of these beds located in 31 hospitals, need to be completely replaced and need not be included in the state total to meet Federal Regulations, so that in reality there are 2,316 general hospital beds, or 4.9 beds per thousand of population. At the ratio of 5.5 beds per thousand, established by Federal Regulations, 2,623 beds in general hospitals are authorized, leaving a balance of 307 beds to be provided under the State Plan. These figures are based on the Department of Commerce, Bureau of the Census, estimated population of Montana, July 1, 1946, of 476,894."

Page 8a Area R-5, Col. (9) should be 56 instead of 40 as shown.
Col. (10) " " 36 " " 20 " "
Area I-4, Col. (12) " " 76 " " 104 " "
Col. (13) " " 224 " " 252 " "
Col. (14) " " 76 " " 104 " "

Page 8b Area I-6, Col. (9) should be 0 instead of 69 as shown.
Col. (10) " " 0 instead of 41 " "
Col. (11) " " 0 " " 28 " "
Totals, Col.(9) " " 727 " " 780 " "
Col. (10) " " 412 " " 437 " "
Col. (11) " " 315 " " 343 " "
Col. (12) " " 315 " " 343 " "
Col. (13) " "3043 " " 3071 " "
Col. (14) " " 727 " " 755 " "

Page 8 e Area I-4, Col. (7) should be 76 instead of 104 as shown.
Col. (8) " "224 " " 252 " "
Miles City, Col. (7) " " 57 " " 85 " "
Miles City, Col. (8) " "122 " " 150 " "
Total, Col. (7) " "220 " " 248 " "
Total, Col. (8) " "428 " " 456 " "

Page 9 Paragraph I-4, change to read: "Seventy-six beds allocated from the pool. This provides fifty-seven beds to Holy Rosary Hospital in Miles City, which is now operating at a very high percentage of occupancy, permitting one hundred twenty-two beds there. It also provides for nineteen beds at Baker to replace the existing facility now operating with a very high percentage of occupancy.

Page 10a Area R-13, Col. (5). Priority should be "B" instead of "A" as shown.

Area I-4, Col. (7) should be 53 instead of 59 as shown.

Under "Community" insert in Col. (5) "A-1"; in Col. (6) "Whitehall (I-6)"; in Col (7), "0".

THE STATE PLAN

FOR THE CONSTRUCTION OF HOSPITALS AND

HEALTH CENTERS IN THE STATE OF MONTANA

BASED UPON THE REQUIREMENTS OF PUBLIC LAW NO. 725

"THE HOSPITAL SURVEY AND CONSTRUCTION ACT"

Approved by:

Hospital Advisory Council	December 11, 1947
State Board of Health	January 8, 1948
Public Hearing	January 8, 1948

Submitted to Surgeon General
U.S. Public Health Service
January 16, 1948

FOREWORD

In order that funds made available to States, by Public Law 725 of the 79th Congress for construction of hospital and health centers, could be accepted by Montana, the 30th Legislative Assembly passed Chapter 270 of the Session Laws of 1947 designating the State Board of Health as the sole agency for the administration of the act.

In compliance with the requirements of such law, the State Board of Health has made a survey of existing hospital facilities within the State and has projected a tentative Plan for such added construction as will best meet the needs of the people in the respective areas within the State.

The State Board of Health recognizes that any State Plan can not be an unchangeable document and the Plan as presented will be subject to continuous study and will be reviewed and revised from time to time as condition and need indicate.

The State Plan has been developed in conformity to the Federal Law and the regulations that have been promulgated for compliance therewith. All future changes or revisions likewise will need be developed under the same authority.

Our sincere appreciation and thanks are expressed to all the hospital administrators, committees and others for their cooperation in furnishing to the State Board of Health the statistical data and assembling of material necessary for the formulation of the tentative Plan.

It is desired and sincerely hoped that as a result of this study and tentative State Plan, there will develop sufficient interest throughout the State that a cooperative system of hospitals and health centers may be developed that will provide such needed services to all the people within the State.

B. K. KILBOURNE, M.D.
Executive Officer
State Board of Health

MEMBERS OF STATE BOARD OF HEALTH

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Mr. R. J. Losleben . . . . . Havre

Mr. Otto Brackman . . . . . Helena

B. K. Kilbourne, M.D., Executive Officer, Helena.

HOSPITAL ADVISORY COUNCIL

Name	Profession or Interests Represented
Dr. B. K. Kilbourne (Helena)	Chairman, ex-officio, Executive Officer, State Board of Health
Dr. L. S. Crary (Fairfield)	Physician, Rural Medicine
Walter Neils (Libby)	Lumber Industry, Construction Groups
Carl Lindquist (Scobey)	Lawyer, Formerly ChiefJustice, Montana Supreme Court, Rural Areas
Mrs. Peter Yegen, Jr. (Billings)	Women's Clubs
S. H. Riven (Missoula)	Labor Organizations, Montana Federation of Labor
Dr. F. I. Terrill (Galen)	Physician, State Agencies
Milo Dean (Great Falls)	Business Administrator, Clinics and Hospitals
Gordon Holt (Hot Springs)	Automobile Business, Consumer, Rural Areas
W. F. Flinn (Miles City)	Newspaper Publisher, Radio, Consumers in Eastern Montana
*Mrs. Walter Melin (Livingston)	Women's Clubs
W. J. Fouse (Helena)	Administrator, Public Welfare, State Agencies
Rev. Frank Harrington (Butte)	Catholic Hospital Association
Carl F. Kraenzel (Bozeman)	Rural Sociologist, Agricultural Experiment Station, Montana State College
Rev. G. T. Bergee Shelby)	Lutheran Hospitals & Homes Society Lutheran Welfare Work in Montana
A. B. Applegren (Wolf Point)	Banker, Rural Areas

*Resigned, January 1, 1948

P E R S O N N E L

HOSPITAL SURVEY AND CONSTRUCTION DIVISION

STATE BOARD OF HEALTH

B. K. KILBOURNE, M.D., EXECUTIVE OFFICER
Helena, Montana

- - - - - - - - - - -

Robert J. Munzenrider, Consulting Engineer
Vincent H. Walsh, Consulting Architect
Marjorie DuMez, R.N., Consultant
Alice L. Henry, Senior Stenographer

THE PLAN FOR CONSTRUCTION OF HOSPITALS
AND
HEALTH CENTERS IN THE STATE OF MONTANA

The 79th Congress enacted Public Law No. 725, known as the Hospital Survey and Construction Act. The purpose of the Act was to assist the States:

(a) To inventory their existing hospitals,
(b) To survey the need for construction of hospitals and to develop programs for construction of such public and other non-profit hospitals as will in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people, and
(c) To construct public and other non-profit hospitals in accordance with such program.

To participate in the program, the Law requires that the States comply with specific provisions of the Act:

(a) To designate a single State Agency as the sole agency for carrying our the purposes of the Act,
(b) To provide for the designation of a State Advisory Council, and
(c) To provide for making an inventory and survey.

The enactment by the Montana Legislature of Chapters 269 and 270 of the 1947 Session Laws, which were subsequently signed by Governor Sam C. Ford, enables the State of Montana to comply with all the requirements of the Federal Law. Chapter 270, the State Hospital Survey and Construction Act, establishes the Board of Health as the sole agency, authorizes the inventory and survey, and provides for the Advisory Hospital Council, which includes representatives of non-governmental organizations or groups, and of State Agencies concerned with the operation, construction and utilization of hospitals, including representatives of the consumers of hospital services. Chapter 269 provides for the licensing, inspection, and regulating of hospitals throughout the State. The Federal Law requires that minimum standards for maintenance and operation be established for hospitals which receive Federal Aid under the Act. The State Licensing Law, as passed, is intended to apply to all hospitals (except Federal) since minimum standards are equally desirable in public or tax supported hospitals as in voluntary institutions.

Thus the fundamental steps to assure Montana's participation in the program were adequately arranged.

The evolution of the State Plan for hospital construction is presented in the following outline form:

I. THE SURVEY OF HOSPITAL FACILITIES

During 1945 an inventory and survey of the existing hospitals and public health facilities in Montana was made. The study was made at the request of the Governor, Hon. Sam C. Ford, by a committee known as the Montana Hospital Survey Committee. Carl F. Kraenzel, Associate Professor of Rural Sociology at Montana State College, carried the major responsibility for the work of this Committee and his report may be read in full in Bulletin 438 of the Montana State College Agricultural Experiment Station, entitled "The Hospitals of Montana, Existing Facilities and Attendant Problems."

We quote from the conclusion of that study:

(1) "Measured in terms of bed facilities to population, Montana hospital facilities rank high in comparison with available indexes for the Nation as a whole and most other states. However, this fact alone does not mean that Montana has sufficient and adequate hospital facilities.

(2) Certain areas of Montana are distinctly under hospitalized and need additional hospital facilities, to be on a par with the rest of the State.

(3) Not all the present facilities are in the proper location with respect to needs within the State as a whole and within the individual areas. This is true even of areas with a high bed-population index. The predominantly rural areas are especially neglected.

(4) Many of Montana's present hospital bed facilities are housed in buildings that should be abandoned, since they are very old and non-fire-resistant, were never originally intended for hospital purposes, or are inconvenient and embarrassing from the standpoint of location and hospital service and administration ***.

(5) Montana also has a large number of small hospitals, too small for economical operation. ***

(6) If present hospital construction plans all materialize, it does not follow that the present inequities will be corrected. In some instances, such inequities will become less pronounced; in others, they will be intensified, or at least continued.

(7) There is need for studying present facilities and proposed construction, not just from the standpoint of the single community, but in the framework of an entire area and from the standpoint of the total State situation before finally going into a construction program. A statewide plan is needed as a guide for hospital location and distribution.

(8) When plans are made for hospital construction, the problem of adequate financing is important, but that of financing current operations is still more important. Furthermore, there is a real danger in so overemphasizing the problems connected with construction that little or no attention is given to the problems of operating hospitals."

In surveying the existing facilities and in the development of a long range plan it was advisable to consider certain beds as replaceable and to exclude them from the count of acceptable hospital beds. Beds were considered to be replaceable when:

(a) The buildings were not originally constructed as a hospital.

(b) The buildings were obsolete, needing replacement.

(c) The beds were not rendering community service.

In addition it is to be noted that the two facilities of the Northern Pacific Beneficial Association a percentage of the beds do not offer community service. Accordingly fifteen beds in the Northern Pacific Hospital in Missoula and 30 beds in the Nathern Pacific Hospital in Glendive were the only ones tabulated since they offer true community service.

II. BASIC CONSIDERATIONS IN MAKING THE STATE PLAN

The purpose of the inventory and survey was to provide information and statistics from which a State Plan can be formulated. The State Plan designates locations of medical installations, based upon a study and analysis of available information that will affect present and future trends in hospital requirements. From existing hospitals and the use people make of them, hospital service areas can be located. The population in the area is then a prominent factor in determining to what extent existing hospitals should be enlarged or new facilities constructed. The Hospital Service Areas are defined by the regulations as (1) the Base Area, (2) the Intermediate Area, and (3) the Rural Area. The definitions of these areas, taken from the Regulations for the Hospital Survey and Construction Act, are as follows:

1. A Base Area is an area with a teaching hospital of a medical school or an area with at least 100,000 population and one general hospital with complement of 200 or more beds for general use.

2. An Intermediate Area has a population of 25,000 or more, and, on completion of the hospital and construction program, would have at least one general hospital of 100 beds suitable for a district hospital in a co-ordinated hospital system.

3. The Rural Area is the remaining area, no part of which is included in a base or intermediate area.

In as much as Montana has neither a medical school nor an area with a population of 100,000, we do not logically have a "base area". Montana has, therefore, been divided into six intermediate areas and twenty-four rural areas. This regional plan is conceived in view of an integrated hospital system in which diagnostic and treatment facilities are made available to all. In such a system, specialists from the larger hospitals may render consultative services to the smaller rural area hospitals. Also in such a system, patients requiring specialized observation and treatment may be transferred from the smaller to the larger hospitals in which all types of services can be provided. The purpose of such planning is to decentralize or spread out from the larger centers to the remote hamlets, all the benefits modern medicine has to offer. The one or two physicians, the public health nurse and the limited staff of a small community clinic would not be expected to offer the same comprehensive service found in the large general hospitals, but the rural community clinic would be linked with the larger hospital and may draw on it for help with diagnostic and therapeutic problems beyond its own resources.

The hospital service areas were developed in what appeared to be the most logical basis, taking into account the following:

(a) Population distribution,

(b) Natural geographic boundaries,

(c) Location of retail trade centers,

(d) Location of highways and railroads and,

(e) Time-travel factors.

For the purposes of this plan the following definitions have been developed:

General Hospital and Community Clinic -- A general hospital and community clinic is any hospital for in-patient medical or surgical care of acute illness or injury and for obstetrics, of which not more than 50%

of the total patient days during the year are customarily assignable to the following categories of cases: Chronic, convalescent and rest, drug and alcoholic, epileptic, mentally deficient, mental, nervous and mental, and tuberculosis.

District Hospital*— A district hospital is a general hospital located in an intermediate area that contains, or will contain a complement of 100 or more beds on completion of the hospital construction program under the state plan, and which may be used as a center for referrals within the area.

Area Hospital — An area hospital is a general hospital located in either an intermediate or a rural area which may be used as a referral center for the nearby rural hospitals and community clinics.

Rural Hospital*— A rural hospital is a general hospital having a complement of twenty to one hundred beds for general use.

Community Clinic*— A Community Clinic is a small rural hospital unit of 8 to 20 beds with equipment for normal maternity service, emergency medical and surgical service and other community health facilities as indicated.

Mental Hospital — A mental hospital is a hospital for the diagnosis and treatment of nervous and mental illness but excluding institutions for the feebleminded and epileptics.

Psychopathic Hospital — A psychopathic hospital is a type of mental hospital where patients may receive intensive treatment and where only a minimum of continued treatment facilities will be afforded.

Tuberculosis Hospital — A tuberculosis hospital is a hospital for the diagnosis and treatment of tuberculosis, excluding preventoria.

Chronic Disease Hospital — A chronic disease hospital is a hospital, the primary purpose of which is medical treatment of chronic illness, including the degenerative diseases, and which furnishes hospital treatment and care, administered by or under the direction of persons licensed to practice medicine in the State. The term includes such convalescent homes as meet the foregoing qualifications. It excludes tuberculosis and mental hospitals, nursing homes, and also institutions, the primary purpose of which is domiciliary care.

Public Health Center — A public health center is a publicly owned facility utilized by a local health unit for the provision of public health services including related facilities such as laboratories, clinics and administrative offices.

Local Health Office — A local health office is a single county-

city or local district health unit as well as a state health district unit where the primary function is the direct provision of public health services to the population under its jurisdiction. (Suggested facilities: nurses office, conference room, doctor's office, small utility room, examining room which may be the doctor's office, and a bathroom)

*Note: Any of the above institutions should be encouraged to include facilities for all local health activities.

III. THE ALLOCATION OF HOSPITAL BEDS TO EACH AREA.

General Hospitals:

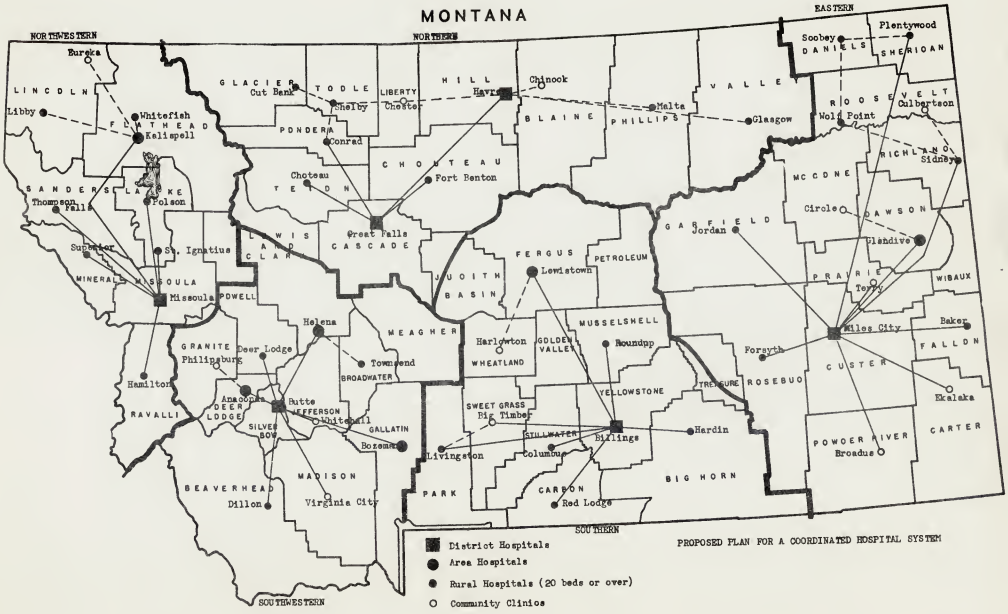
The State of Montana has 146,316 square miles, and a population of 3.8 people per square mile. The total population of 492,240 is established by the latest figures of the school census. Using these figures, the State is authorized a general hospital bed ratio of 5.5 beds per thousand population. This is subdivided into 5 beds per thousand in an intermediate area and 3.5 beds per thousand in the rural areas.

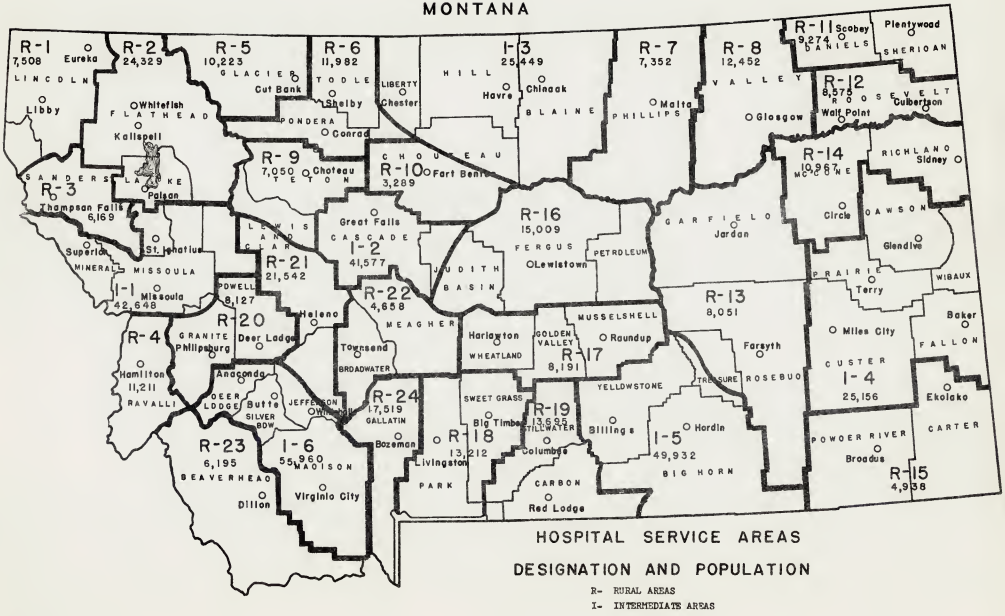
The mathematical difference between the over-all State ratio of 5.5 beds per thousand and the area ratios of 5 and 3.5 beds per thousand is called the "general bed pool". For example, a rural hospital service area of 10,000 people is authorized 35 beds to take care of its needs, because it has been determined that the population of rural areas use general hospital beds at the ratio of 3.5 per thousand. In the state total, however, these 10,000 people accounted for 55 beds because the over-all State ratio is based on 5.5 per thousand. The difference between the 35 beds and the 55 beds are considered "pool beds". These pool beds may be distributed to take care of areas where abnormal circumstances put them in a position of requiring more beds than their particular area ratio would normally allow.

Montana has at present 63 general hospitals with a total of 2,861 beds, or 5.8 per thousand population, somewhat higher than the over-all requirements. However, 586 of these beds located in 31 hospitals, need to be completely replaced and need not be included in the state total to meet Federal Regulations, so that in reality there are 2275 general hospital beds or 4.6 per thousand of population. At the ratio of 5.5 per thousand, established by Federal Regulations, 2707 beds in general hospitals are authorized, leaving a balance of 432 to be provided under the State Plan.

The need of hospital beds having been established, there are a number of factors which must be balanced against each other in arriving at the size of hospital most suitable for a particular area.

Studies show that the average occupancy varies in proportion


MONTANA
NORTHWESTERN
NORTHERN
EASTERN
SOUTHERN
SOUTHWESTERN
Eureka
Libby
Whitefish
Kalispell
LINCOLN
FLATHEAD
GLACIER
Cut Bank
TOOLE
Shelby
LIBERTY
Chester
HILL
Havre
Chinook
VALLEE
Malta
Glasgow
Scobey
Plentywood
DANIELS
SHERIDAN
ROOSEVELT
Wolf Point
Culbertson
RICHLAND
Sidney
PONDERA
Conrad
BLAINE
PHILLIPS
CHOUTEAU
Fort Benton
TETON
Choteau
SANDERS
LAKE
Polson
Thompson Falls
Great Falls
CASCADE
LEWIS AND CLARK
Superior
St. Ignatius
MINERAL
MISSOULA
Missoula
POWELL
FERGUS
Lewistown
PETROLEUM
JUDITH BASIN
GARFIELD
Jordan
MCCONE
Circle
DAWSON
Glendive
PRAIRIE
Terry
WIBAUX
Helena
MEAGHER
Harlowton
GOLDEN VALLEY
MUSSELSHELL
Roundup
Miles City
Baker
FALLON
CUSTER
Forsyth
TREASURE
ROSEBUD
Ekalaka
GRANITE
Philipsburg
Deer Lodge
Townsend
BROADWATER
WHEATLAND
Hamilton
RAVALLI
Anaconda
DEER LODGE
Butte
JEFFERSON
Whitehall
SILVER BOW
GALLATIN
Bozeman
SWEET GRASS
Big Timber
YELLOWSTONE
STILLWATER
Columbus
Livingston
Billings
Hardin
POWDER RIVER
Broadus
CARTER
BEAVERHEAD
Dillon
MADISON
Virginia City
PARK
CARBON
Red Lodge
BIG HORN
District Hospitals
Area Hospitals
Rural Hospitals (20 beds or over)
Community Clinics
PROPOSED PLAN FOR A COORDINATED HOSPITAL SYSTEM



HOSPITAL SERVICE AREAS

DESIGNATION AND POPULATION

R- RURAL AREAS

I- INTERMEDIATE AREAS

to the size of the hospital, - the larger the hospital the greater the average occupancy. If the average occupancy of existing hospitals is high in an area, that area would have greater justification for additional beds from the pool than another area with the same bed ratio and having a lower average occupancy. The following table indicates the expected percentage of occupancy in hospitals:

Size of Hospital No. of Beds	Expected Percentage Occupancy Low	High
10	30	40
20	42	52
30	49	58
40	54	62
50	57	66
60	60	68
75	63	71
100	67	74
150	72	78
200	75	81
300	79	84
500	83	87

Small hospitals of 10 to 50 beds can be expected normally to have lower percentage occupancies than larger hospitals, and the income per bed will naturally be less than in hospitals with a higher occupancy rate. The small hospital, generally, may be constructed and operated at a lower cost per bed, for the diagnostic equipment such as basal metabolism equipment, electrocardiograph, encephalograph and laboratory facilities which are usually found in the larger hospitals, increase the costs.

It should be recognized that in building a small hospital there will be a sacrifice in medical facilities. Complete diagnostic services and expensive equipment cannot usually be included in the small hospital. Hospital construction today is extremely expensive, costs varying between $10,000 and $13,000 per bed. In general, the larger the hospital, the better equipped it will be and the more efficient and economical it is to operate. However, in rural areas it is often difficult to justify a hospital of sufficient size to permit efficiency and economy of operation. There may, however, be a need for a facility for ambulatory and outpatient care, obstetrics, and immediate emergency care before transportation of the patient to a larger hospital. For this purpose the "community clinics" are planned, to distinguish them from the larger hospitals.

In determining the need for hospital beds in each area, beyond the beds needed on the basis of area and population, consideration was given to the following factors:

(a) The utilization of existing facilities as shown by the percentage of occupancy.

(b) The existence of hazardous industries in the area.

(c) The need for community clinics in rural areas.

(d) The replacement of facilities which were deemed replaceable.

This thinking is shown in detail as follows:

R-1 Because of the hazardous nature of the lumber industry nineteen beds are allocated to this area from the pool. This allows a ten bed community clinic at Eureka and a thirty-five bed facility at Libby.

R-2 Twenty-nine beds allocated from the pool because of the trend toward a greater population increase and the high percentage of occupancy of the present facilities.

R-6 Twenty beds allocated from the pool in order to take care of the needs of Shelby in replacing the present seventeen bed facility. Shelby is located in an oil region.

R-7 Four beds allocated from the pool in order to permit construction of a thirty bed facility in a top priority area.

R-11 Eighteen beds allocated from the pool in order to provide for a thirty bed facility at Plentywood and a twenty bed facility at Scobey. Each of these will replace existing facilities operating at high occupancy percentages.

R-12 Ten beds from the pool are allocated in order to provide for a community clinic at Culbertson. The thirty beds allowed on the basis of area population have been allocated to Wolf Point, where the present replaceable facilities are operating at a very high occupancy percentage.

R-13 Twenty-three beds allocated from the pool in order to provide for replacement of the present facility at Jordan.

R-15 Eight beds allocated from the pool in order to provide for a community clinic of ten beds at Broadus which at present has no facilities.

R-17 Eleven beds allocated from the pool in order to provide for a community clinic of ten beds at Harlowton. One additional bed was allocated to Roundup from the pool which, with the beds allowed on the basis of area population, will allow a thirty bed facility there.

R-18 Fourteen beds allocated from the pool in order to provide for a community clinic of ten beds at Big Timber. The four additional beds are allocated to Livingston which, with the beds allowed on area population, will provide for a fifty bed facility.

R-19 Seven beds allocated from the pool which, with the beds

PHS-7(HF)
5-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R399
EXPIRATION DATE SEPT. 30, 1948

GENERAL BED DISTRIBUTION REPORT

1. PAGE 1 OF 2
2. DATE 1/12/48
3. STATE Montana

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

AREA AND REGION	POPULATION	BED ALLOWANCES BASED ON		EXISTING ACCEPTABLE BEDS	DETERMINATION OF POOL BEDS			BEDS ALLOCATED TO AREA FROM STATE POOL	TOTAL BEDS NEEDED	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED IN AREA (Col. 13 minus Col. 8)
		STATE RATIO	AREA RATIO		TOTAL (Col. 6 minus Col. 8)	WITHIN AREA (Col. 7 minus Col. 8)	OR, STATE POOL (Col. 9 minus Col. 10)			
(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
Northwestern										
R-1	7,508	41	26	0	41	26	15	19	45	45
R-2	24,329	134	85	86	48	0	48	30	116	30
R-3	6,169	34	22	0	34	22	12	0	22	22
R-4	11,211	62	39	33	29	6	23	0	39	6
I-1	42,648	235	213	172	63	41	22	0	213	41
Northern										
R-5	10,223	56	36	0	40	20	20	0	36	36
R-6	11,982	66	42	57	9	0	9	20	77	20
R-7	7,352	40	26	0	40	26	14	4	30	30
R-8	12,452	68	44	60	8	0	8	0	60	0
R-9	7,050	39	25	0	39	25	14	0	25	25
R-10	3,289	18	12	41	0	0	0	0	41	0
I-2	41,577	229	208	396	0	0	0	0	396	0
I-3	25,449	140	127	163	0	0	0	20	183	20
Eastern										
R-11	9,274	51	32	0	51	32	19	18	50	50
R-12	8,575	47	30	0	47	30	17	10	40	40
R-13	8,051	44	28	23	21	5	16	23	51	28
R-14	10,967	60	38	22	38	16	22	0	38	16
R-15	4,938	27	17	15	12	2	10	8	25	10
I-4	25,156	138	126	148	0	0	0	104	252	104
*										
	TOTALS									

*NOTE: -*If report requires more than one sheet, enter total on LAST SHEET ONLY and cut off bottom of other sheet on this line.*

PHS-7(HF)
5-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R299
EXPIRATION DATE SEPT. 30, 1948

GENERAL BED DISTRIBUTION REPORT

1. PAGE 2 OF 2
2. DATE 1/12/48
3. STATE Montana

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

AREA AND REGION (4)	POPULATION (5)	BED ALLOWANCES BASED ON STATE RATIO (6)	BED ALLOWANCES BASED ON AREA RATIO (7)	EXISTING ACCEPTABLE BEDS (8)	DETERMINATION OF POOL BEDS: TOTAL (Col. 6 minus Col. 8) (9)	DETERMINATION OF POOL BEDS: WITHIN AREA (Col. 7 minus Col. 8) (10)	DETERMINATION OF POOL BEDS: CH. STATE POOL (Col. 9 minus Col. 10) (11)	BEDS ALLOCATED TO AREA FROM STATE POOL (12)	TOTAL BEDS NEEDED (13)	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED IN AREA (Col. 13 minus Col. 8) (14)
Southern										
R-16	15,009	83	53	119	0	0	0	0	119	0
R-17	8,191	45	29	0	45	29	16	11	40	40
R-18	13,212	73	46	0	73	46	27	14	60	60
R-19	13,695	75	48	0	75	48	27	7	55	55
I-5	49,932	275	250	228	47	22	25	0	250	22
Southwestern										
R-20	8,127	45	28	36	9	0	9	10	46	10
R-21	21,542	118	75	271	0	0	0	25	296	25
R-22	4,658	26	16	28	0	0	0	0	28	0
R-23	6,195	34	22	22	12	0	12	0	22	0
R-24	17,519	96	61	82	14	0	14	0	82	0
I-6	55,960	308	280	314	69	41	28	20	334	20
*State-wide	15,346	-84			-84		-84			
TOTALS		2623	2084	2316	780	437	343	343	3071	755

*NOTE: -*If report requires more than one sheet, enter total on LAST SHEET ONLY and cut off bottom of other sheet on this line.*

* This represents pool bed adjustment for difference in population between 1946 Dept. of Commerce estimate of 476,894 and State estimate of 492,240

PHS-10 (HF)
5-47

GENERAL HOSPITALS SUMMARY

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R303
EXPIRATION DATE SEPT. 30, 1948

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

ATTACH TO THIS FORM THE STATEMENT CALLED FOR IN THE INSTRUCTIONS.

1. PAGE 1 OF 5
2. DATE 1/12/48
3. STATE Montana
4. REGION Northwestern

AREA AND COMMUNITY IN WHICH EXISTING ACCEPTABLE OR PROPOSED FACILITY IS OR WILL BE LOCATED (5)	EXISTING ACCEPTABLE BEDS (6)	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED (7)	TOTAL BEDS NEEDED (8)	NUMBER OF FACILITIES (9)
R-1	0	45	45	2
Libby	0	35	35	1
Eureka	0	10	10	1
R-2	86	30	116	3
Whitefish	30	0	30	1 (1)
Kalispell	36	30	66	1 (1)
Polson	20	0	20	1 (1)
R-3	0	22	22	1
Thompson Falls	0	22	22	1
R-4	33	6	39	1
Hamilton	33	6	39	1 (1)
I-1	172	41	213	5
Superior	24	0	24	1 (1)
St. Ignatius	42	0	42	1 (1)
Missoula	106	41	147	3 (3)
TOTAL	291	144	435	12

Note: Number in parenthesis in Column 9 indicates number of existing facilities.

NOTE: -If report requires more than one sheet, enter totals on LAST SHEET ONLY and cut off bottom of other sheets on this line.

PHS-10(HF)
S-67

GENERAL HOSPITALS SUMMARY

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R301
EXPIRATION DATE SEPT. 30, 1948

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

ATTACH TO THIS FORM THE STATEMENT CALLED FOR IN THE INSTRUCTIONS.

1. PAGE 2 OF 5
2. DATE 1/12/48
3. STATE Montana
4. REGION Northern

AREA AND COMMUNITY IN WHICH EXISTING ACCEPTABLE OR PROPOSED FACILITY IS OR WILL BE LOCATED (5)	EXISTING ACCEPTABLE BEDS (6)	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED (7)	TOTAL BEDS NEEDED (8)	NUMBER OF FACILITIES (9)
R-5	0	36	36	1
Cut Bank	0	36	36	1
R-6	57	20	77	2
Conrad	57	0	57	1 (1)
Shelby	0	20	20	1
R-7	0	30	30	1
Malta	0	30	30	1
R-8	60	0	60	1
Glasgow	60	0	60	1 (1)
R-9	0	25	25	1
Choteau	0	25	25	1
R-10	41	0	41	1
Fort Benton	41	0	41	1 (1)
I-2	396	0	396	2
Great Falls	396	0	396	2 (2)
I-3	163	20	183	4
Chester	0	10	10	1
Chinook	0	10	10	1
Havre	163	0	163	2 (2)

Note: Number in parenthesis in Column 9 indicates number of existing facilities

TOTAL	717	131	848	13

NOTE: -If report requires more than one sheet, enter totals on LAST SHEET ONLY and cut off bottom of other sheets on this line.

PHS-10(HF)
5-47

GENERAL HOSPITALS SUMMARY

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R301
EXPIRATION DATE SEPT. 30, 1948

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

ATTACH TO THIS FORM THE STATEMENT CALLED FOR IN THE INSTRUCTIONS.

1. PAGE 3 OF 5
2. DATE 1/12/48
3. STATE Montana
4. REGION Eastern

AREA AND COMMUNITY IN WHICH EXISTING ACCEPTABLE OR PROPOSED FACILITY IS OR WILL BE LOCATED (5)	EXISTING ACCEPTABLE BEDS (6)	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED (7)	TOTAL BEDS NEEDED (8)	NUMBER OF FACILITIES (9)
R-11	0	50	50	2
Scobey	0	20	20	1
Plentywood	0	30	30	1
R-12	0	40	40	2
Wolf Point	0	30	30	1
Culbertson	0	10	10	1
R-13	23	28	51	2
Jordan	0	28	28	1
Forsyth	23	0	23	1 (1)
R-14	22	16	38	2
Circle	0	10	10	1
Sidney	22	6	28	1 (1)
R-15	15	10	25	2
Broadus	0	10	10	1
Ekalaka	15	0	15	1 (1)
I-4	148	104	252	5
Glendive	70	0	70	2 (2)
Terry	13	0	13	1 (1)
Baker	0	19	19	1
Miles City	65	85	150	1 (1)
TOTAL	208	248	456	15

Note: Number in parenthesis in Column 9 indicates number of existing facilities.

NOTE: -If report requires more than one sheet, enter totals on LAST SHEET ONLY and cut off bottom of other sheets on this line.

PHS-10 (HF)
5-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 69-R301
EXPIRATION DATE SEPT. 30, 1948

GENERAL HOSPITALS SUMMARY

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

ATTACH TO THIS FORM THE STATEMENT CALLED FOR IN THE INSTRUCTIONS.

1. PAGE 4 OF 5
2. DATE 1/12/48
3. STATE Montana
4. REGION Southern

AREA AND COMMUNITY IN WHICH EXISTING ACCEPTABLE OR PROPOSED FACILITY IS OR WILL BE LOCATED (5)	EXISTING ACCEPTABLE BEDS (6)	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED (7)	TOTAL BEDS NEEDED (8)	NUMBER OF FACILITIES (9)
R-16	119	0	119	1
Lewistown	119	0	119	1 (1)
R-17	0	40	40	2
Harlowton	0	10	10	1
Roundup	0	30	30	1
R-18	0	60	60	2
Livingston	0	50	50	1
Big Timber	0	10	10	1
R-19	0	55	55	2
Columbus	0	25	25	1
Red Lodge	0	30	30	1
I-5	228	22	250	3
Billings	215	15	230	2 (2)
Hardin	13	7	20	1 (1)
TOTAL	347	177	524	10

Note: Number in parenthesis in Column 9 indicates number of existing facilities

*NOTE: *If report requires more than one sheet, enter totals on LAST SHEET ONLY and cut off bottom of other sheets on this line.*

PHS-10 (HF)
5-47

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R301
EXPIRATION DATE SEPT. 30, 1948

GENERAL HOSPITALS SUMMARY

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

ATTACH TO THIS FORM THE STATEMENT CALLED FOR IN THE INSTRUCTIONS.

1. PAGE 5 OF 5
2. DATE 1/12/48
3. STATE Montana
4. REGION Southwestern

AREA AND COMMUNITY IN WHICH EXISTING ACCEPTABLE OR PROPOSED FACILITY IS OR WILL BE LOCATED (5)	EXISTING ACCEPTABLE BEDS (6)	NET ADDITIONAL BEDS WHICH MAY BE CONSTRUCTED (7)	TOTAL BEDS NEEDED (8)	NUMBER OF FACILITIES (9)
R-20	36	10	46	2
Philipsburg	0	10	10	1
Deer Lodge	36	0	36	1 (1)
R-21	271	25	296	4
Helena	271	25	296	4 (4)
R-22	28	0	28	1
Townsend	28	0	28	1 (1)
R-23	22	0	22	1
Dillon	22	0	22	1 (1)
R-24	82	0	82	1
Bozeman	82	0	82	1 (1)
I-6	314	20	334	5
Anaconda	75	0	75	1 (1)
Butte	239	0	239	2 (2)
Whitehall	0	10	10	1
Virginia City	0	10	10	1
TOTAL	753	55	808	14

Note: Number in parenthesis in Column 9 indicates number of existing facilities

NOTE: -If report requires more than one sheet, enter totals on LAST SHEET ONLY and cut off bottom of other sheets on this line.

allowed on area population, allow fifty-five for the area. This will provide for a thirty bed facility at Red Lodge and a twenty-five bed facility at Columbus.

R-20 Ten beds allocated from the pool to allow for a ten bed community clinic at Philipsburg.

R-21 Twenty-five beds allocated from the pool for the enlargement of an orthopedic hospital at Shodair which serves the population of the entire state.

I-3 Twenty beds allocated from the pool to provide ten bed community clinics at Chester and Chinook.

I-4 One hundred four beds allocated from the pool. This provides eighty-five beds to Holy Rosary Hospital in Miles City, which is now operating at a very high percentage of occupancy, permitting one hundred fifty beds there. It also provides for nineteen beds at Baker to replace the existing facility now operating with a very high percentage of occupancy.

I-6 Twenty beds allocated from the pool to provide for community clinics at Virginia City and Whitehall.

Without physicians, hospitals are of small value and without professional nurses the practice of scientific medicine in even the best equipped hospital is extremely difficult. In Montana, according to the most reliable figures presently available, there is a ratio of one physician for every 1039 of the population. The distribution of physicians throughout the state is very irregular however, and while there are some counties with a very high ratio, such as Cascade with one doctor for every 656 of the population, many others have a low ratio, for example Carter County, where there is only one physician for the 3280 people living there. In two counties there are no physicians at all. The situation relative to professional nurses is very similar.

While economic conditions may account for this situation in part, they are not the only factors. The advances in medical science and the development of medical specialties has extended the role of the hospital and increased the need for conferences and consultations among physicians. Medical education stresses the use of modern methods of diagnosis and therapy necessitating well equipped institutions staffed with competent physicians, surgeons and other specialists. Such a program induces an unwillingness in the young physician to enter upon practice in regions where similar facilities and services are not available. Without adequate hospitals or similar facilities, young physicians will not willingly go to rural areas.

IV. AREA AND PROJECT PRIORITY

In order to facilitate the equitable distribution of Federal funds available for general hospital construction, a system of priorities was established. This system gives full consideration to the factors outlined in Public Law 725 and the Federal Regulations, namely, the relative need for beds in an area and provision for services for people living in rural areas.

All area priorities are based on the need presently met by existing acceptable hospital beds within an area as applied against the total general bed needs of that area. The areas were grouped into five priority groups on the basis of percentage of need met as follows:

Group A	0-10% need met
Group B	11-45% need met
Group C	46-70% need met
Group D	71-90% need met
Group E	91-100% need met

In determining the priority of individual projects the area priority is of major importance. However, in order to better effectuate the provisions of the Regulations providing for priority in instances where zero percentage of need is met, and to adequately provide for the residents of rural communities, all communities in the State with zero percent of need met are treated as if they were located in A priority areas. Thus ten communities with no portion of their current hospital needs met by existing acceptable beds are classified ashaving an "A-1" priority. In no instances do the beds planned for such communities exceed thirty in number.

Insofar as practicable, the State Board of Health will develop its construction program in relation to the proportionate need for each of the five categories of facilities (general, mental, tuberculosis, chronic, and health centers). In determining proportionate needs, consideration will be given to existing facilities and those under construction without assistance under the Federal Act.

Initial installations and additions to existing acceptable facilities will be given priority over replacements except (a) where replacement is of minor character and necessary to the provision of acutely needed additional facilities, or (b) where replacement is essential to eliminate an existing needed facility which constitutes a public hazard.

Projects in lower priority areas will not normally be considered above a project in a higher priority area unless such project is more urgently required for providing a service on a statewide basis which will not otherwise be provided in the higher priority areas.

PHS-73(HF)
5-47

RELATIVE NEED REPORT

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R304
EXPIRATION DATE SEPT. 30, 1948

NOTE: - SEE REVERSE SIDE FOR INSTRUCTIONS ON THIS FORM.
This form must be submitted for:
a. General Hospitals
b. Chronic Disease, Mental and Tuberculosis Hospitals only if programmed on LESS THAN STATE WIDE BASIS.

This form SHOULD NOT be filled out for Public Health Centers.

1. PAGE 1 OF 1
2. DATE 1/12/48
3. STATE Montana
4. CATEGORY

PRIORITY (5)	AREA (6)	PERCENTAGE OF NEED MET (7)	PRIORITY (5)	AREA (6)	PERCENTAGE OF NEED MET (7)
A	R-1	0	E	I-5	91
A	R-3	0	E	R-21	92
A	R-5	0	E	I-6	94
A	R-7	0	E	R-8	100
A	R-9	0	E	R-10	100
A	R-11	0	E	R-16	100
A	R-12	0	E	R-22	100
A	R-17	0	E	R-23	100
A	R-18	0	E	R-24	100
A	R-19	0	E	I-2	100
A	R-13	45		Community	
C	R-14	58	A-1	Baker (I-4)	0
C	I-4	59	A-1	Broadus (R-15)	0
C	R-15	60	A-1	Chester (I-3)	0
D	R-2	74	A-1	Chinook (I-3)	0
D	R-6	74	A-1	Circle (R-14)	0
D	R-20	78	A-1	Jordan (R-13)	0
D	I-1	81	A-1	Philipsburg (R-20)	0
D	R-4	85	A-1	Shelby (R-6)	0
D	I-3	89	A-1	Virginia City (I-6)	0

Tuberculosis, nervous and mental, and chronic disease beds will be allocated on a statewide basis and priorities on these projects will be determined at the time construction of projects is being considered. Special consideration will be given facilities in these categories when they are to be constructed in connection with existing hospitals and for areas where there is a high prevalence of any of the above diseases, and where facilities are not presently available.

V. HOSPITAL BEDS FOR SPECIALIZED SERVICES

Modern thinking in the care of specialized conditions such as tuberculosis, cardiac conditions and mental conditions, is that such patients are better cared for in general hospitals or in buildings erected as units of a general hospital. In this way the specialized services of the general hospital can be utilized for these patients as needed, and duplication of expensive equipment is eliminated.

For new nervous and mental hospitals, the regulation states:

> "Whenever practicable, mental hospitals receiving grants under the Federal Act shall be located in centers of population and in proximity to general hospitals."

In such an arrangement, the facilities of the general hospitals may be utilized when needed for patients in the nervous and mental hospitals.

Mental Disease Hospitals:

Beds in hospitals for mental diseases are authorized at the ratio of 5 per thousand population, or a total of 2795 for Montana. The Hospital at Warm Springs has 1800 beds, leaving 995 to be provided.

Some of the beds needed for nervous and mental patients should be in psychopathic and psychiatric wards in or attached to general hospitals. Beds are needed for patients not frankly psychotic, for borderline cases for whom intensive treatment and mental hygiene may be beneficial. The need in Montana, at present, is for the establishment of such facilities in or attached to general hospitals.

Tuberculosis Hospitals:

Beds for tuberculosis are authorized at the rate or 2.5 times the average deaths from that disease during the five year period 1940 to 1944 inclusive.

At present the survey shows a total of 235 beds now available for patients with tuberculosis. These are located at the Montana Tuberculosis

Sanitarium in Galen, which is the only facility in Montana. According to the state ratio 497 beds are allowed, leaving a minimum of 262 beds to be provided.

The location of tuberculosis hospitals receiving grants under the Federal Act is designated according to regulations as follows:

> "Whenever practicable, tuberculosis hospitals receiving grants under the Federal Act shall be built in centers of population and in proximity to general hospitals."

The location of a tuberculosis hospital adjacent to a general hospital has several valuable advantages. Training and experience for the internes and residents of the general hospitals can be arranged. General hospital facilities can be utilized when necessary for tuberculosis patients. The tuberculosis hospital can become a center for consultation service with private physicians.

Chronic Disease Hospitals:

Beds in hospitals for chronic diseases are allowed at the rate of 2 per thousand of population. This should therefore provide 954 beds for the State. Montana does not have any hospitals especially designed for patients with chronic diseases, but we know that many of our hospitals for acute conditions are using some of these beds for this purpose.

The Federal Regulations are similar in regard to chronic disease hospitals:

> "Whenever practicable, chronic disease hospitals shall be built in centers of population and in proximity to general hospitals and priority shall be given to those projects in which the chronic disease facilities will be operated as sub-units of general hospitals."

The daily cost for patients in chronic disease hospitals is usually much less than for patients in general hospitals. This lower cost is due to the longer period of stay, lesser needs of medical and surgical facilities and nursing care. However, because of occasional needs for surgical and medical care, patients should be housed in sub-units of a general hospital or in a hospital in close proximity to a general hospital.

VI. HEALTH CENTER FACILITIES

Provision for construction of Health Centers has been made in the Hospital Survey and Construction Act, Public Law No. 725, with the following Statement regarding State allowance:

PHS-11(HF)
5-47

TUBERCULOSIS, MENTAL,
CHRONIC DISEASE SUMMARY

NOTE:- SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R302
EXPIRATION DATE SEPT. 30, 1948

1. PAGE 1 OF 1
2. DATE 1/12/48
3. STATE Montana
4. AREA Montana

DESCRIPTION OF Mental Disease FACILITIES
Tuberculosis, Mental, Chronic Disease

5. POPULATION	6. ANNUAL AVERAGE NO. OF T.B. DEATHS IN STATE 1940 - 1944 INCL.	7. TOTAL BEDS ALLOWED BY STATE RATIO
476,894		2384
8. TOTAL EXISTING ACCEPTABLE BEDS	**9. NET ADDITIONAL BEDS NEEDED *(Item 7 minus Item 8)***	
1800	584	

10. ADDITIONAL FACILITIES PROPOSED FOR STATE

COMMUNITY (a)	IDENTIFICATION OF FACILITY *(Attach Additional Sheets If Necessary)* (b)	NET ADDITIONAL NUMBER OF BEDS (c)
Warm Springs	Montana State Hospital	200
Warm Springs	Psychiatric Unit at Montana State Hospital	150
Unallocated		234
(d) TOTAL ADDITIONAL NUMBER OF BEDS		584

11. COMMENTS *(Attach Additional Sheets If Required)*

234 beds have not been allocated at this time. It is planned that they will be constructed as sub-units of general hospitals

PHS-11(HF)
5-47

TUBERCULOSIS, MENTAL,
CHRONIC DISEASE SUMMARY

NOTE:- SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R302
EXPIRATION DATE SEPT. 30, 1948

1. PAGE 1 OF 1
2. DATE 1/12/48
3. STATE Montana
4. AREA Montana

DESCRIPTION OF Tuberculosis FACILITIES
Tuberculosis, Mental, Chronic Diseases

5. POPULATION	6. ANNUAL AVERAGE NO. OF T. B. DEATHS IN STATE 1940 - 1944 INCL.	7. TOTAL BEDS ALLOWED BY STATE RATIO
476,894	199	497

8. TOTAL EXISTING ACCEPTABLE BEDS	9. NET ADDITIONAL BEDS NEEDED *(Item 7 minus Item 8)*
235	262

10. ADDITIONAL FACILITIES PROPOSED FOR STATE

COMMUNITY (a)	IDENTIFICATION OF FACILITY *(Attach Additional Sheets if Necessary)* (b)	NET ADDITIONAL NUMBER OF BEDS (c)
Galen	Montana State Tuberculosis Sanitarium	150
Unallocated		112
(d) TOTAL ADDITIONAL NUMBER OF BEDS		262

11. COMMENTS *(Attach Additional Sheets if Required)*

112 beds have not been allocated at this time. It is planned that they will be constructed as sub-units of general hospitals.

PHS-11(NF)
5-47

TUBERCULOSIS, MENTAL,
CHRONIC DISEASE SUMMARY

NOTE:- SEE REVERSE SIDE FOR INSTRUCTIONS ON USE OF THIS FORM

FEDERAL SECURITY AGENCY
U. S. PUBLIC HEALTH SERVICE
WASHINGTON 25, D. C.

FORM APPROVED
BUREAU OF BUDGET NO. 68-R302
EXPIRATION DATE SEPT. 30, 1948

1. PAGE 1 OF 1
2. DATE 1/12/48
3. STATE Montana
4. AREA Statewide

DESCRIPTION OF Chronic FACILITIES
Tuberculosis, Mental, Chronic Diseases

5. POPULATION	6. ANNUAL AVERAGE NO. OF T.B. DEATHS IN STATE 1940 - 1944 INCL.	7. TOTAL BEDS ALLOWED BY STATE RATIO
476,894		954
8. TOTAL EXISTING ACCEPTABLE BEDS	**9. NET ADDITIONAL BEDS NEEDED** *(Item 7 minus Item 8)*	
none	954	

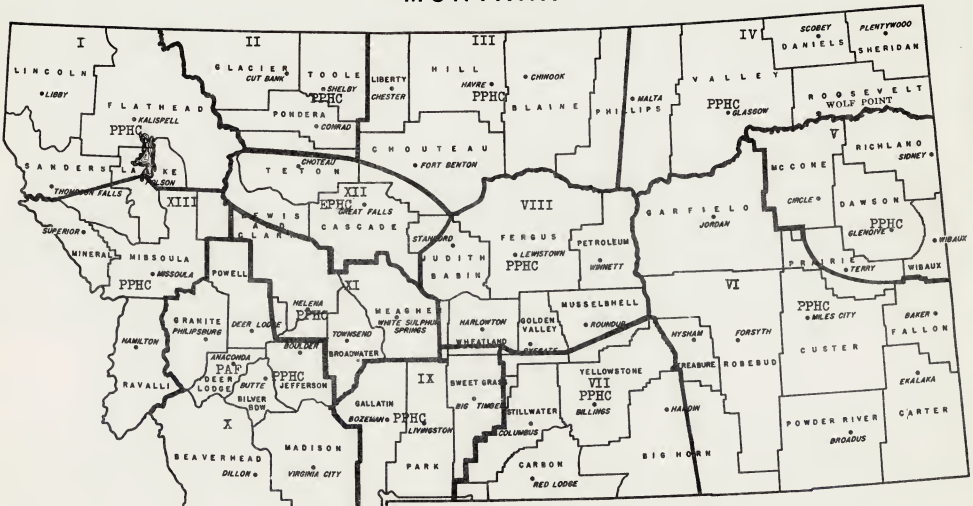
10. ADDITIONAL FACILITIES PROPOSED FOR STATE

COMMUNITY (a)	IDENTIFICATION OF FACILITY *(Attach Additional Sheets if Necessary)* (b)	NET ADDITIONAL NUMBER OF BEDS (c)
	It is not possible at present to designate communities or facilities for the construction of chronic beds. It is planned, however, that chronic facilities will be constructed as sub-units of general hospitals	
(d) TOTAL ADDITIONAL NUMBER OF BEDS		

11. COMMENTS *(Attach Additional Sheets if Required)*

No form 5 submitted since there are at present no acceptable chronic beds in the state.

MONTANA



EPHC Existing Public Health Center
PPHC Proposed Public Health Center
PAF Proposed Auxiliary Facility

PUBLIC HEALTH CENTERS

"The number of Public Health Centers in a state (counting those existing as well as those provided with aid under the Act) shall not exceed one per 20,000 of state population. The existing facilities determined to be unsuitable shall be excluded."

On the basis of our population, we are authorized a total of 28 centers.

The basis for development of the Public Health Centers in the tentative state plan is the result of the study made by the Division of Local Health Services in cooperation with Dr. Haven Emerson of Columbia University. Health center areas, as shown on the accompanying map, were suggested in the report of that study, dated 1945. It is planned to have one Public Health Center in each of the thirteen areas, and, in addition, a Local Health Office in Anaconda. Since there is one acceptable Public Health Center in the State at the present time, there remain twelve Public Health Centers and one Local Health Office to be constructed.

VII. METHODS OF ADMINISTRATION

1. Public Hearing Of The State Plan And Publicity Relative To It.

(1) A general discussion of the proposed State Plan was released through the United Press and Associated Press on December 11 & 12, 1947. This news service covers most of the leading newspapers in the state as well as radio broadcasting stations.

A public hearing of the plan was held on January 8, 1948, in the Chambers of the House of Representatives in the State Capitol in Helena.

(2) After approval of the State Plan by the United States Public Health Service, the State Board of Health will take steps to insure publication of a general description of the State Plan in newspapers of general circulization throughout the state. In addition, societies, organizations and associations will be urged to cooperate in bringing the essential portions and provisions of the State Plan to the attention of interested and affected parties, persons, organizations and associations.

(3) One approved copy of the State Plan will be available at all times in the State Board of Health for public examination.

2. Establishment Of The Project Construction Schedule.

(1) After approval of the State Plan by the United States Public Health Service, the State Board of Health will develop a Project Construction Schedule which will list the projects for which construction can be commenced immediately. The schedule will be developed by soliciting applications from

sponsoring agencies in areas of the greatest unfilled need and in the order of the area priorities as shown in the over-all construction program. The number of projects included on the Project Construction Schedule will depend upon the amount of Federal allotment to the state.

(2) Project will be selected for the Project Construction Schedule after consideration of the following factors:

(a) The priority of the project as determined in accordance with the principles outlined in the State Plan for determination of need.

(b) The intent of the sponsoring agencies to begin construction within a reasonable length of time.

(c) The ability of the sponsoring agency to meet the financial requirements for construction, maintenance and operation of the proposed facility.

(d) The maintenance of an appropriate balance in the construction of the various categories of facilities (i.e., general, tuberculosis, mental and chronic disease hospitals and public health centers). The balance between categories of facilities need not be reflected in each Project Construction Schedule. However, construction which is scheduled over the five-year program will reflect an appropriate balance between the various categories of facilities.

(3) If a project is removed from the Project Construction Schedule by the State Board of Health, the schedule will be revised to include the next highest priority project which meets the requirements for inclusion.

After the approval of the schedule, a project will not be removed therefrom except when an applicant must be dropped by reason of his:

(a) Failure to submit required documents.

(b) Failure to comply with the present rules and regulations, such as inability to meet the financial requirement or failure to prepare plans and specifications, or

(c) Voluntary withdrawal.

(4) The fact that a project is excluded from the Project Construction Schedule for any of several reasons will not change the project priority rating (although for other reasons this priority may change). Such projects will be considered for inclusion in each succeeding Project Construction Schedule.

(5) If a project is in the highest priority group, Part I of the

Project Construction Application, which is prescribed by the Public Health Service, may be approved and forwarded prior to approval of the Project Construction Schedule. If the project is not in the highest priority group, Part I of the Project Construction Application will be submitted with the schedule.

(6) The first Project Construction Schedule will be submitted to the appropriate Public Health Service District Office no sooner than 30 days after approval of the State Plan. This waiting period is provided to enable highest priority projects to develop construction interest and furnish the essential financial assurances. Thereafter, the schedule will be submitted on or before July 1st of each year.

(a) (NOTE: Because of the wide publicity given the State Hospital Survey and Construction Program through the press and radio, a large number of "A" priority projects are already in a position to present their preliminary applications as soon as they receive the application blanks, after the State Plan has been approved. For that reason, it was considered that 30 days would be ample time to allow before submitting "A" priority applications. Other priority projects will be held up a longer period of time.

(7) Applications for Federal Assistance under Public Law 725 will be submitted on the Project Construction Application which is prescribed by the Public Health Service.

3. Standards of Construction and Equipment

(1) The State Board of Health, has adopted as its general standards of construction and equipment Appendix A as amended of the Regulations issued pertinent to Public Law 725, 79th Congress.

(2) Copies of such standards are available for inspection at the State Board of Health. Also copies of the regulations and Appendix A as amended have been mailed to each registered architect in Montana and all others who have requested the same.

4. Inspection by the State Department of Health

When a request for payment of an installment is made, the State Board of Health will make an inspection of the project to determine that services have been rendered, work has been performed, and purchases have been made as claimed by the applicant and in accordance with the approved project application. In addition, the State Board of Health will make such additional inspections as are deemed necessary. Reports of each inspection will be retained in the files of the State Board of Health,

5. Construction Payments

(1) Requests for construction payments shall be submitted by app-

licants to the State Board of Health at the times prescribed by Section 53.78 (a) of the regulations as amended.

(2) Under existing law, the State is authorized to make payment of federal funds to all types of applicants.

(3) Federal funds shall be paid to State Treasurer.

(4) The State will promptly remit or credit all payments of Federal funds received by the State for payment to applicants for approved construction projects.

6. Establishment and Maintenance of Personnel Standards on a Merit Basis.

All personnel employed in administering the State Plan will be appointed under and subject to the merit system maintained by the State Merit System Council. The Merit System Council will furnish the Public Health Service with such data and information as is necessary to determine compliance with the Act and regulations.

Rules and regulations governing the merit system are not attached since they are on file with the U.S. Public Health Service and have been held to meet Federal requirements on other grants-in-aid programs.

7. Fiscal and Accounting Procedures.

(1) The State Board of Health will comply with the provisions of Section 53.79 of the regulations by maintaining the necessary accounting records and controls, and requiring applicants for Federal funds to maintain adequate fiscal records and controls.

(2) The State Board of Health agrees that it will retain on file all documents coming into its possession which relate to any expenditure under Public Law 725. In addition, the State Board of Health will take such steps as are necessary to assure that applicants (1) retain all relevant and supporting documents, and (2) establish suitable property inventory records covering all equipment of more than nominal value.

(3) The State Board of Health further agrees that it will:

(a) Retain the accounting records, controls and documents described in 1 and 2 above for a period of at least one year beyond its participation in the program.

(b) Take such steps as are necessary to assure that applicants retain the fiscal records, controls and documents described in 1 and 2 above for a period of at least two years after the final payment of Federal funds.

Minimum Standards of Operation and Maintenance

The State Board of Health has adopted regulations prescribing minimum standards of operation and maintenance for all hospitals receiving aid under the Hospital Survey and Construction Act.

VIII STATEMENT OF NON-DISCRIMINATION

No application for general hospital construction will be approved under this plan unless the applicant includes therein the following statement:

> "The applicant hereby assures the State Board of Health that no person in the area will be denied admission as a patient to the facility on account of race, creed or color."

The applicant must also give assurance that a reasonable volume of free patient care will be furnished for persons unable to pay. By "free patient care" is meant hospital service offered below cost or free to persons unable to pay therefor, including under "persons unable to pay therefor," both the legally indigent and persons who are otherwise selfsupporting but are unable to pay the full cost of needed hospital care. In determining what constitutes a reasonable volume of free patient care, there shall be considered conditions in the area to be served by the applicant, including the amount of free care that may be available otherwise.than through the applicant.

IX FAIR HEARING PROCEDURE

The following rules and regulations governing the Fair Hearing Procedure have been adopted by the State Board of Health:

(1) The State Board of Health will provide an opportunity for a fair hearing to every applicant who has requested Federal aid in hospital construction, is dissatisfied with the action of the State Board of Health, and appeals for a hearing.

(2) Actions of the State Board of Health which entitle applicants to a hearing include the following:

(a) Denial of opportunity to make formal application.

(b) Rejection or disapproval of application, and

(c) Refusal to reconsider an application.

(3) Appeals from decisions or actions of the State Board of Health

must be made by the applicant, in writing, within thirty days from the date of the adverse decision by the State Board of Health.

(4) The appellant will be notified in writing of the time and place of hearing. The time and place of the hearing which is determined by the State Board of Health will be reasonably convenient for the appellant.

(5) The appellant is entitled to be represented by friends or counsel, if he so desires. The appellant and other persons interested and concerned with the State Board of Health's decision are entitled to present pertinent evidence in the way desired subject to reasonable procedures of admissibility and methods of presentation.

(6) The appellant is entitled to examine all evidence and to question opposing witnesses.

(7) Whenever practicable, the presiding officer will be an official in a responsible position who did not participate in the action from which the appeal is made.

(8) The decision of the State Board of Health will be made in writing within thirty days from the date of the hearing, and will be based on the evidence presented at the hearing.

(9) A stenographic record of the hearing will be made, and, upon request of the appellant, will be transcribed and made available for examination.